香港申訴專員公署
Office of The Ombudsman, Hong Kong



主動調查報告
Direct Investigation Report

私家醫院低收費病床的使用
Utilisation of low-charge hospital beds in private hospitals

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Executive Summary
Direct Investigation Report

Utilisation of Low-charge Hospital Beds in Private Hospitals

Introduction

Two private hospitals in Hong Kong (hereunder referred to as "Hospital A" and "Hospital B") are required to comply with the land grant conditions and provide no less than 20% of their total beds as low-charge hospital beds. As at December 2019, the two hospitals are providing a total of 164 low-charge beds. The relevant requirements stipulate that the daily hospital charges for a low-charge bed shall not exceed the maximum fee charged for a third-class bed in public hospitals[1], while other hospital charges shall not exceed half the similar charges for a second-class bed in the private hospital concerned.

2. The number of low-charge beds may not appear to be high, but if each patient stays for two to four days on average and the admission rates of the low-charge beds reach 80%, these beds can handle about 12,000 to 24,000 attendances of patients each year. Optimising the use of low-charge beds can help alleviate the burden of the entire healthcare system and complement with the Government policy to encourage the use of private healthcare services.

3. Prior to 2012, the two private hospitals had not strictly complied with the requirements for low-charge beds under the land grant conditions. In response to the Audit Commission's criticism in its report in 2012 ("the 2012 Report"), the Government has gradually stepped up its monitoring of these hospitals' compliance with land grant conditions with regard to their provision of low-charge beds. Besides, the Government has recommended the two hospitals to introduce measures to improve the utilisation rates of their low-charge beds. We appreciate the Government's positive attitude and efforts in this aspect.

4. That said, this direct investigation has revealed room for improvement in the Government's promotion of the use of low-charge beds as well as in the referral arrangements between the Hospital Authority ("HA") and the two private hospitals

[1] In December 2019, the daily fee for a third-class bed in public hospitals was $120.

during influenza surges.

Our Findings

(I) Government Should Keep Observing and Reviewing Policy of Low-charge Beds

5. The Government noted that as the land grant conditions for the two private hospitals do not include conditions on the use of low-charge beds (including their utilisation rates), it is difficult to enforce the relevant requirements. Moreover, provision of low-charge beds had had little effect on encouraging members of the public to go to private instead of public hospitals. Hence, in January 2011, the Executive Council ("ExCo") decided to introduce the requirements for service packages to replace those for low-charge beds when renewing the land leases with private hospitals.

6. When ExCo made that decision in January 2011, the requirements for low-charge beds had not been effectively implemented and the utilisation rates of those beds were very low. In Hospital A's case, the utilisation rates of low-charge beds were then between 23% and 45%[2]. Compared with the utilisation rates in or before 2011, there have been significant improvement. Currently, the utilisation rates in Hospital A and Hospital B could reach 70% to 80%. Given that there are many years ahead before the land leases for Hospital A and Hospital B expire in 2047 and 2060 respectively, we consider that it is worth reviewing the Government's policy of low-charge beds before the land leases concerned expire.

7. Although the Government stressed that provision of low-charge beds has not helped much in encouraging public hospital patients to switch to the private healthcare services, we still find those low-charge beds useful in that they provide incentive to people who can afford private healthcare services and help alleviate the burden of public hospitals under HA when necessary. Furthermore, inclusion of the requirements for low-charge beds in the land grant conditions has given a clear indication to the private hospitals concerned that land grants at concessionary premiums come with social responsibility. Upon strengthening the Government's enforcement of the requirements, there were marked increases in the utilisation rates of low-charge beds. That means proper implementation of the requirements is not impossible.

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2 In the aforesaid 2012 report, the utilisation rate of low-charge beds in Hospital A in 2008 was 1%, and the relevant rates between 2009 and 2011 ranged from 23% to 45%.

8. The policy of low-charge beds provides incentive for people who can afford private healthcare services and is complementary to service packages and voluntary medical insurance introduced in recent years. Service packages and low-charge beds are not contradictory, and there is no need for the Government to choose between them. One possible option is to let private hospitals offer low-priced service packages using their low-charge beds.

9. We are of the view that provision of service packages in private hospitals is still at an initial stage. The Government should closely monitor the use of low-charge beds, and proactively explore ways to better utilise those beds and revisit the relevant policy when reviewing that of service packages.

(II) HA Should Better Utilise Low-charge Beds to Divert Patients to Private Healthcare Sector

10. In recent years, the Government has attempted to address the imbalance in demand between the public and private healthcare services by encouraging those who could afford higher charges to go to the private sector. In our view, although HA is under no obligation to monitor and improve the utilisation of low-charge beds, better utilisation of those beds can help alleviate the burden of public hospitals and spare more resources for patients in need. This direct investigation has revealed the following areas for improvement in HA's use of low-charge beds to divert patients to the private healthcare sector.

(1) <u>Introducing Measures to Address the Ineffectiveness of Referral Agreements during Influenza Surges</u>

11. HA has signed agreements with Hospital A and Hospital B to refer inpatients of public hospital to use their low-charge beds during outbreaks of infectious diseases or influenza surges. Yet, during the three previous influenza surges[3] when the referral agreements were activated, HA had referred only a very small number of patients[4]. In two influenza surges, Hospital B had only accepted two public hospital patients in total.

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[3] The 2017/18 summer and winter surges of influenza and the 2018/19 winter surge of influenza.

[4] Hospital A accepted 25 to 35 patients referred during each influenza surge while Hospital B accepted two in total.

12. HA's explanation was that strict criteria for referral were necessary to ensure patients' safety. Thus, only patients in stable clinical conditions could be referred. In selecting cases, frontline staff found that most patients were not suitable for referral. Nonetheless, we find it necessary that HA investigate why patient referrals during influenza surges have been ineffective and review the existing arrangements.

Explore Relaxation of Restrictions on Referral of Patients

13. We understand that it is rather difficult for HA to select suitable cases for referral among emergency cases from surgical and medicine wards, which are particularly under stress during influenza surges. On the other hand, some of the patients in the surgical and medicine wards may need to be transferred to other wards such as convalescent and infirmary wards for continual care or other therapies when their condition becomes stable. We are of the view that HA could explore the relaxation of restrictions on referral of patient (including the 7-day limit of stay), and consider also patients from other wards, such as convalescent/infirmary wards. Hence, the turnover rates of hospital beds could be enhanced, thereby alleviating the burden on the surgical and medicine wards.

Improve and Simplify the Administrative Work of Referrals

14. A public hospital doctor revealed to us that public hospitals did not have adequate manpower to select suitable patients for referrals, and they had to cope with the heavy workload brought by the relevant administrative work. Hence, the selection could only be made on weekdays. In our view, the arrangement of referral is meant to alleviate the burden of public hospitals during influenza surges. If the relevant administrative work is too complicated, it will defeat the purpose of such arrangement and discourage frontline staff from referring patients to use low-charge beds. HA should explore ways to simplify the administrative work in selecting patients for referral.

15. Moreover, while the referral agreements are activated, the two private hospitals are required to reserve certain numbers of low-charge beds for patient referrals. Previously, many of those beds were wasted as the numbers of referrals had been very small. HA should, therefore, collaborate with the two private hospitals on improving the flexibility of the reservation arrangement.

Consider Making Referral to Use Low-charge Beds a Standing Arrangement

16. In our opinion, depending on the effectiveness of referrals in future, HA can proactively explore the feasibility of making standing arrangements for referrals of patients beyond influenza surges, so that they do not need to wait until the public hospitals are already under great pressure. Besides, medical personnel can have more time to arrange referrals during off-peak seasons and gain experience in making referrals, thus enhancing its overall effectiveness.

(2) Exploring Feasible Ways to Better Utilise Low-charge Beds

17. In addition, we consider that HA should collaborate with the two private hospitals to explore other feasible measures to better utilise the low-charge beds so as to divert patients from public hospitals. Feasible measures may include ways to encourage those patients who have made appointments or are waiting to receive treatment to use the low-charge beds in private hospitals. For example, the private hospitals can offer more concessionary terms or provide low-priced service packages to public hospital patients who agree to use low-charge beds. Moreover, subject to the needs for public hospitals' services, HA can examine which items of hospitalisation are suitable for offering subsidies to patients to use low-charge beds under public-private partnership programmes.

(III) The Government Should Explore Ways to Further Publicise Use of Low-charge Beds

18. Since we declared the launch of this direct investigation in July 2019, there were public responses showing that many people including private medical practitioners are not aware of the low-charge bed services. We consider that the Government can further publicise such services and improve the utilisation rates by addressing the following aspects.

(1) Strengthening Promotion of Low-charge Beds among Public Hospital Patients

19. The Department of Health ("DH") considered that it should not be assisting private hospitals in the publicity or promotion of their services (including the low-charge bed services) to avoid conflicts with its role as the monitoring authority. We should point out that provision of low-charge beds originated from the land grants to the two private hospitals due to the concessionary premiums offered, and therefore, those beds

involve public resources and are different from commodities and services provided by ordinary private organisations. Hence, the Government should provide the public with sufficient information about low-charge beds.

20. In our opinion, the Government could use various channels to step up its promotion of low-charge beds among members of the public, such as putting up posters or notices in public hospitals under HA. It should also proactively explore other means to make low-charge beds more appealing to patients who can afford higher charges so that they would be encouraged to use private healthcare services. For example, the Government could suggest that private hospitals offer low-priced service packages using their low-charge beds.

(2) Encouraging Hospital B to Provide More Low-charge Beds in Its New Wing

21. Low-charge beds in Hospital B are located within the hospital's Old Wing since the hospital started to provide such services. Relevant information shows that most patients of Hospital B refused to use low-charge beds because they wanted to be admitted to the wards in the New Wing. In response to the Government's proposal, Hospital B started to provide low-charge beds in the Surgical and Gynaecology Wards in its New Wing in 2018, but most of the hospital's low-charge beds are still in its Old Wing. We consider that the Government can discuss with Hospital B on further increasing the number of low-charge beds in the New Wing.

(3) Recommend Private Hospitals To More Actively Publicise Their Low-charge Beds and Improve the Provision

22. The Government should discuss with the private hospitals whether they can use their websites or other channels to enhance publicity of the low-charge beds. They can follow the practice of car parks to display the number of available low-charge beds in real time at the hospital lobby as well as releasing regularly the utilisation rates of such beds.

23. Moreover, some patients are reluctant to use low-charge beds because they are concerned about being labelled, or they misunderstand that the equipment and services of such beds are of lower standards. The Government should suggest that the two hospitals address such misunderstanding and negative impression. For example, the hospitals can indicate clearly that low-charge beds are of the same standards and they deliver the same services as ordinary hospital beds do. The hospitals can also rename such beds, giving them a more positive connotation (e.g. concessionary beds).

Furthermore, as private medical practitioners often refer patients to public or private hospitals, the two private hospitals can provide regular information to all private medical practitioners in Hong Kong on the low-charge bed services.

Recommendations

24. In view of the above, The Ombudsman has made the following nine recommendations to **the Food and Health Bureau ("FHB"), DH and HA**:

FHB and DH

(1) proactively explore ways to better utilise low-charge beds and revisit the relevant policy when reviewing the policy of service packages;

(2) make good use of various channels to strengthen its promotion of low-charge beds among members of the public, such as putting up posters or notices in public hospitals;

(3) proactively explore other means to make low-charge beds more appealing, such as making suggestions to the two private hospitals about using their low-charge beds to offer service packages at lower prices;

(4) discuss with Hospital B on further increasing the number of low-charge beds in its New Wing;

(5) suggest the two private hospitals enhance the publicity of their low-charge beds, such as providing regular information to all private medical practitioners in Hong Kong on the low-charge bed services, and addressing the misunderstanding and negative impression that patients might have about those beds;

HA

(6) review the arrangement for referral of patients during influenza surges to investigate why it has been ineffective, review the existing arrangements and make improvement. For example, relaxing the restrictions on referral of patients and simplifying the relevant administrative work;

(7) improve the reservation arrangement for low-charge beds when the referral agreements are activated during influenza surges to avoid wasting resources;

(8) depending on the effectiveness of referrals in future, proactively consider allowing such referrals to be made beyond influenza surges; and

(9) collaborate with the two private hospitals to explore other feasible measures to better utilise the low-charge beds for diversion of public hospital patients, such as encouraging patients who have made appointments or are waiting to receive treatment to use the low-charge beds in private hospitals, and to explore the possibility of referring patients to low-charge beds under public-private partnership programmes.

Office of The Ombudsman
July 2020

1

INTRODUCTION

BACKGROUND

1.1 Two private hospitals in Hong Kong are required to comply with the land grant conditions laid down by the Government and provide no less than 20% of their total beds as low-charge hospital beds. As at December 2019, the two hospitals are providing a total of 164 low-charge beds. The Department of Health ("DH") monitors the provision of low-charge beds by these hospitals to ensure their compliance with the land grant conditions.

1.2 The relevant requirements stipulate that the daily hospital charges for a low-charge bed shall not exceed the maximum fee charged for a third-class bed in public hospitals[1], while other hospital charges shall not exceed half the similar charges for a second-class bed in the private hospital concerned. The preliminary inquiry by the Office of The Ombudsman found that although the two private hospitals have provided low-charge beds in accordance with the land grant conditions, and DH has monitored their compliance, there is still room for improvement in the utilisation rates of those beds.

1.3 Meanwhile, the Hospital Authority ("HA") has signed agreements with the two private hospitals to refer suitable public hospital patients to use their low-charge beds during influenza surges. Patients referred only need to pay a fee equivalent to the basic hospital charges of public hospitals while the other fees would be borne by HA. Yet, the number of referrals was rather small when HA subsequently activated the referral agreements. That means the existing referral mechanism has not been effective in alleviating the strong demand for public hospital beds.

1.4 In this light, The Ombudsman initiated a direct investigation pursuant to section 7(1)(a)(ii) of The Ombudsman Ordinance (Cap. 397) on 4 June 2019 against the Food and Health Bureau ("FHB"), DH and HA to examine the Government's work in

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1 In December 2019, the daily fee for a third-class bed in public hospitals was $120.

monitoring and promoting the use of low-charge beds in private hospitals and identify any areas for improvement.

SCOPE OF INVESTIGATION

1.5 The scope of this direct investigation covers:

- the land grant conditions relating to low-charge beds;
- DH's measures to monitor the private hospitals' compliance with the land grant conditions relating to low-charge beds;
- the provision of low-charge beds in the private hospitals;
- the utilisation rates of low-charge beds; and
- the effectiveness of HA's referrals of public hospital patients to use the low-charge beds in the private hospitals during influenza surges.

PROCESS OF INVESTIGATION

1.6 The Ombudsman declared this direct investigation and invited public views on this topic on 10 July 2019. Apart from conducting site inspections at the two private hospitals providing low-charge beds, we also interviewed separately representatives from these hospitals in August 2019.

1.7 We issued the draft investigation report to the Government (i.e. FHB and DH) and HA for comment on 5 November 2019, and received their comments on 3 and 14 January 2020 respectively. This final report, incorporating the comments from them, was completed on 7 July 2020.

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REQUIREMENTS FOR AND PROVISION OF LOW-CHARGE BEDS

BACKGROUND

2.1 Most private hospitals in Hong Kong were founded decades ago, and they were usually built on Government sites granted or sold by private treaty[2] (i.e. private treaty grant ("PTG")). Land grant conditions were subject to the decision of the Executive Council ("ExCo") when granting the sites.

2.2 In April 1957, ExCo decided that specific conditions should be included when granting Government sites to non-profit-making private hospitals at nil or nominal premium. Such conditions included the provision of free or low-charge beds and services to the satisfaction of the then Director of Medical and Health Services (now the Director of Health ("D of H")).

2.3 In March 1981, ExCo introduced more specific terms in the conditions of land grants to private hospitals. ExCo decided that Government sites directly granted to non-profit-making private hospitals at nil or nominal premium should be subject to conditions including provision of no less than 20% of the total number of beds as low-charge beds. ExCo also set out specific standards of charges for low-charge beds (see **para. 2.7**).

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2 In general, the Government offers Government land for sale by way of public auction or tender. Government sites are sometimes granted to non-profit-making organisations for special purposes by private treaty.

LAND GRANT CONDITIONS RELATING TO LOW-CHARGE BEDS

2.4 According to a report published by the Audit Commission ("Aud") in 2012[3] ("the Report"), the Government had, as early as 1957, made the policy decision to include the requirements for low-charge beds in the conditions of PTGs to private hospitals, and then in 1981 approved the details of such requirements. Nevertheless, ExCo's decision had not been strictly followed in the direct land grants to private hospitals at nil or nominal premium after 1957. The Report states that it was difficult to examine why the requirements had not been included in some direct land grants to private hospital as relevant old files could not be found.

2.5 Currently, among the 12 private hospitals in Hong Kong, five are wholly and partially operating on PTG sites at nil or nominal premium. However, only two of these five hospitals (hereafter referred to as "Hospital A" and "Hospital B") have had the requirements for low-charge beds included in their land grant conditions in accordance with ExCo's decision.

Hospital A

2.6 Hospital A is located on an area covering a Government site granted in January 1996 at a nominal premium of $1,000, the lease of which will expire on 30 June 2047.

2.7 Based on the standards set by ExCo in 1981 (see **para. 2.3**), the requirements for low-charge beds included in the land grant conditions are as follows:

- *the Hospital shall provide no less than 20% of the total number of beds as low-charge beds at all times.*

- *the daily hospital charges for low-charge beds (including fees for the hospital beds, meals and nursing services) shall not exceed the maximum fee charged for third-class beds in public hospitals (see* **Note 1** in **para. 1.2***). Other hospital charges such as fees for operating theatres, laboratory tests, X-ray examinations and medication shall not exceed half the similar charges applied to second-class beds in the Hospital.*

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3 Chapter 4 "Land grants for private hospital development" of the Director of Audit's Report No. 59.

- *by mutual agreement, D of H and the grantee may utilise the low-charge beds provided that the patients using such beds shall not be chronic patients, and the Government shall pay the daily hospital charges and other hospital charges stipulated in the conditions for such beds.*

Hospital B

2.8 The conditions in the replacement lease granted to Hospital B by private treaty in 1961 stipulated that the grantee shall provide free or low-charge beds. In June 2010, the lease was replaced by another PTG (i.e. the land lot on which the hospital currently locates), which will expire on 17 June 2060, at a nominal premium of $1,000.

2.9 The lease conditions relating to low-charge beds include only the following requirement:

- *the grantee shall provide free or low-charge beds and services as required by and to the satisfaction of D of H.*

2.10 The aforementioned lease conditions were not set in accordance with ExCo's decision in 1981. The number of low-charge beds and the standards of charges had not been set out. It was not until early 2013 that the Government acted on the recommendations in the Report mentioned in **paragraph 2.4** and wrote to Hospital B to require its compliance with the standards set by ExCo in 1981 (see **para. 2.7**) to provide no less than 20% of its hospital beds as low-charge beds.

DH'S MEASURES TO MONITOR PROVISION OF LOW-CHARGE BEDS IN PRIVATE HOSPITALS

2.11 DH is responsible for monitoring the provision of low-charge beds in the two private hospitals in terms of the number of beds and charges to ensure their compliance with the land grant conditions. DH will refer any non-compliance cases found to the Lands Department for follow-up actions.

2.12 Nevertheless, Aud pointed out in the Report (see **para. 2.4**) that the requirements for low-charge beds had not been effectively implemented. In Hospital A's case, the hospital block on the PTG site was opened in 2002 but it was not until 2008 that the hospital started to provide low-charge beds. Hospital B first reported to DH in 2011 that provision of low-charge beds had commenced.

2.13 After the Report was published, DH stepped up its monitoring on the two private hospitals' compliance with the land grant conditions to check whether they had provided the required numbers of low-charge beds. Despite that the land grant conditions do not include any requirement for utilisation rates, the two hospitals would, as required by the Government, submit monthly reports on utilisation of low-charge beds to DH for monitoring purpose. The reports include the utilisation rates in the reporting month and statistical information on the invoice amounts regarding patients using low-charge beds. Moreover, the hospitals are required to submit a list of hospital charges every six months for DH's reference.

2.14 Furthermore, since 2013 and 2014, DH has started to conduct surprise inspections at Hospital A and Hospital B on their provision of low-charge bed services. Such inspections are independent of the inspections for approving applications for private hospital licence.

2.15 During the surprise inspections, DH would check whether the provision of low-charge beds is no less than 20% of the total number of beds in the two hospitals, and whether the hospitals have made known to patients the availability of low-charge beds and provided adequate notices and leaflets about the services. DH would also conduct random checks on the invoices issued for the low-charge beds to ensure that the daily maintenance charge and other hospital charges are subject to the relevant requirements set out in the land grant conditions.

2.16 **Table 1** below shows the number of DH's inspections regarding low-charge beds each year from 2014 to 2018. According to DH, the inspection outcomes revealed that the two private hospitals had complied with the requirements for low-charge beds in the land grant conditions.

Table 1: Number of DH's inspections on low-charge beds

Year	Number of inspections on Hospital A	Number of inspections on Hospital B
2014	2	1
2015	2	2
2016	2	2
2017	2	2
2018	2	3

PROVISION OF LOW-CHARGE BEDS IN THE TWO PRIVATE HOSPITALS

Number of Beds

2.17 The two private hospitals have designated some beds in certain specialist wards in their main blocks as low-charge beds. As at December 2019, Hospital A and Hospital B provided 103 and 61 low-charge beds respectively. Details of provision of low-charge beds in these hospitals are illustrated in **Tables 2 and 3** below.

Table 2: Distribution of low-charge beds in Hospital A

Location	**Accommodation/ Number of beds**	**Number of low-charge beds**
Main Block (6/F) Integrated Ward (Medicine and Surgery)	8-bedded room: 12 Single room: 2	98
Main Block (4/F) Haemodialysis Ward	11 beds	5
Total number of low-charge beds		**103**
(Total number of hospital beds subject to the land grant conditions[4])		**(514)**

4 Only the Main Block of Hospital A located on the lot granted in January 1996 (see **para. 2.6**) is subject to the land grant conditions and the requirements for provision of no less than 20% of the total number of beds as low-charge beds. Other buildings of the Hospital are not on the lot in question and therefore, not subject to the land grant conditions relating to low-charge beds.

Figure 1: Low-charge beds in Hospital A's Integrated Ward (8-bedded room)



Table 3: Distribution of low-charge beds in Hospital B

Location	Accommodation	Number of low-charge beds
Old Wing (3/F) Integrated Unit (Medicine and Surgery)	Single room: 3 2-bedded room: 1 3-bedded room: 2 5-bedded room: 6[5]	37
New Wing (Main Block) (12/F) Gynaecological Unit	3-bedded room: 4	12
New Wing (Main Block) (15/F) Surgical Unit	3-bedded room: 4	12
Total number of low-charge beds		**61**
(Total number of hospital beds subject to the land grant conditions[6])		**(304)**

5 There is only one low-charge bed in one of the 5-bedded rooms.

6 The entire site of Hospital B (including the Old Wing and Main Block of the New Wing) is located on the lot granted in 2010 (see **para. 2.8**), and is subject to the land grant conditions.

Figure 2: Low-charge beds in Gynaecological Unit (3-bedded room) of Hospital B's New Wing



Figure 3: Low-charge beds in Integrated Unit (3-bedded room) of Hospital B's Old Wing



Admission Requirements

2.18 Only patients who are Hong Kong permanent residents can use the low-charge beds in the two private hospitals. No means or assets tests are necessary.

2.19 The low-charge beds are available to patients by appointment via resident doctors of the hospitals or private doctors. Patients receiving day surgeries or care services can also use the low-charge beds, but the day surgeries are limited to those performed under sedation or general anaesthesia. In Hospital A, low-charge beds are also used for providing haemodialysis services.

2.20 Conditions for admission to the low-charge beds in the two hospitals are listed in **Annex**. For Hospital A, low-charge beds are offered to adult patients aged 18 or above, with the length of stay usually limited to seven days. For Hospital B, the conditions for admission stipulate that patients using low-charge beds must be aged 15 or above, and there is no limit on the length of stay.

Hospital Charges

2.21 The charges for low-charge beds in both Hospital A and Hospital B must be in line with the standards mentioned in **paragraph 2.7** above.

2.22 As at December 2019, the two private hospitals were charging low-charge bed patients a daily maintenance charge of $120 (covering the bed, meals and general services), and a fee of $96 for day surgery or care services, which were at the same rates as in public hospitals. Other hospital charges were 50% of the similar charges for second-class wards in these hospitals as stipulated.

2.23 It should be noted that the aforesaid maintenance charge and other hospital charges do not cover the fees charged by doctors such as surgeon's fees, ward round fees and anaesthetist's fees. In other words, patients using low-charge beds shall bear full amount of all the doctors' fees during hospitalisation.

2.24 In addition, Hospital A and Hospital B obtained the Government's consent in 2013 and 2014 respectively, to set up a mechanism for charging fees on expensive items that covered advanced but expensive treatments and drugs. Where the treatment for a patient using a low-charge bed involves expensive items (including drug and non-drug items)[7], the hospital can charge the patient for the purchase of such items plus an

7 Drug items include drugs with the unit price at HK$1,000 or above, or special drugs/self-financed items on the HA Drug Formulary. Where the unit price of a drug is below HK$1,000, but the drug is used for treating patients for serious illness (such as cancer and immune system disease) that requires long-term medication at a charge of more than HK$1,000 per day, DH will give special consideration and approval. Non-drug items include examination/treatment materials and implant of devices at HK$1,000 or above, or medical equipment or services provided or rented out by a third party, whose cost is HK$1,000 or above.

administration fee (around 3% to 10%) thereof under the mechanism. The hospitals shall submit a list of expensive items to the Government every six months. In case there are new expensive items to be added to the list, the hospitals shall submit relevant information to the Government for approval.

2.25 **Tables 4 and 5** show the charges for different classes of beds in Hospital A and Hospital B respectively[8].

Table 4: Charges for different classes of beds in Hospital A

Items	Low-charge bed	Standard ward	Semi-private ward[9]
Daily charge for a hospital bed	Admission: $120 Day care/ operation: $96	$560 to $750	$850 to $1,600
Operating theatre[10]	$1,050 to $6,980	$1,500 to $9,970	$2,100 to $13,960
Tests (Kidney function test)	$405	$580	$810
Chest X-ray examination	$148	$210	$296
Magnetic resonance imaging of brain (2D)	$3,850	$5,500	$7,700

8 Figures as at August 2019.

9 A semi-private ward in Hospital A is equivalent to a second-class ward.

10 The fees for operating theatre in Hospital A are charged according to the types of surgery. The range shown here covers only the fees for common types of surgery.

Table 5: Charges for different classes of beds in Hospital B

Items	Low-charge bed	Standard ward	Second-class ward
Daily charge for a hospital bed	Admission: $120 Day care/operation: $96	$550 to $1,200	$1,600 to $2,500
Operating Theatre[11] **(60 minutes)**	$3,398	$4,530	$6,795
Tests (Kidney function tests)	$666	$888	$1,332
Chest X-ray examination	$203	$290	$406
Magnetic resonance imaging of brain (2D)	$4,130	$5,900	$8,260

2.26 **Tables 4 and 5** show that the daily charges for low-charge beds in Hospital A and Hospital B are much lower than those of other classes of beds. Besides, other hospital charges for low-charge beds are also lower, which are about 30% less than those for standard wards.

Invoice Amounts

Average Invoice Amounts

2.27 Each month, the two private hospitals are required to submit to DH statistical information on the invoice amounts regarding patients using low-charge beds (see **para. 2.13**). **Tables 6 and 7** set out the average invoice amounts settled by patients using low-charge beds in Hospital A and Hospital B in May 2019.

[11] The fees for operating theatre in Hospital B are charged according to duration of use.

Table 6: Invoice amounts settled by patients using low-charge beds in Hospital A (May 2019)

Average length of stay: 2.29 days			
Per invoice			
	Average amount	**At 25th Percentile**	**At 75th Percentile**
Doctor's fees	$10,074	$800	$16,500
Fees charged for hospital's services	$7,556	$3,137	$10,537
Total	**$17,630**	**$3,937**	**$27,037**

Table 7: Invoice amounts settled by patients using low-charge beds in Hospital B (May 2019)

Average length of stay: 2.6 days			
Per invoice			
	Average amount	**At 25th Percentile**	**At 75th Percentile**
Doctor's fees	$21,668	$4,350	$31,500
Fees charged for hospital's services	$20,151	$8,966	$16,462
Total	**$41,819**	**$13,316**	**$47,962**

Case Study

2.28 We have examined some invoices for low-charge beds. In one case, a patient underwent an operation at Hospital B and stayed for three days in 2018. The breakdown of the invoice concerned is set out as follows.

Table 8: Invoice issued to a patient using a low-charge bed in Hospital B

Item	Amount	Total amount
Daily maintenance charge		
Accommodation (3 days)		**$360**
Other hospital charges		
Admission fee	$150	
Non-invasion measurement of blood pressure	$1,035	
Computed tomography (Chest)	$6,790	
Central Supply	$328	
Laboratory tests	$5,383	
Electrocardiogram	$300	
Endoscopy	$4,794	
Oxygen therapy	$128	
Pharmacy	$1,788	
Post-anaesthetic Care Room	$270	
Treatment and related materials	$927	**$21,893**
Doctor's fee		
Anaesthetist's fee	$3,000	
Consultation fee	$2,400	
Surgeon's fee	$12,000	**$17,400**
Total invoice amount		**$39,653**

2.29 Assuming that the charges for low-charge beds are about 70% of those for standard wards, and the patient mentioned in **paragraph 2.28** had been admitted to a 5-bedded standard ward instead of a low-charge bed in Hospital B, the total invoice amount would have been over $10,000 (about 27%) more (see **Table 9**). The fees actually paid (including the hospital charges and doctor's fees) for each case depends on its own merits.

Table 9: Comparison of invoice amounts for low-charge beds and standard wards

Charges	Low-charge beds (Fees actually paid)	5-bedded wards in Old Wing (Estimated fees)
Daily maintenance charge	$360	$1,650[12]
Other hospital charges	$21,893	$31,276[13]
Doctor's fees	$17,400	$17,400
Total invoice amount	**$39,653**	**$50,326**

REPLACING LOW-CHARGE BEDS WITH SERVICE PACKAGES IN LAND GRANT CONDITIONS

2.30 In January 2011, ExCo approved the policy for granting sites for new private hospital developments. Under the policy, private hospital developments on reserved Government sites are subject to a set of minimum requirements including provision of service packages for patients at a lump sum charge whereas provision of low-charge beds is no longer required.

2.31 The Government noted that under the policy approved by ExCo in January 2011, when the private hospitals currently providing low-charge beds in accordance with the land grant conditions (i.e. Hospital A and Hospital B) undergo extension or redevelopment, the Government will discuss with the grantees and add the condition of providing service packages to replace the existing requirements for low-charge beds.

2.32 At present, a private hospital is providing service packages in accordance with the agreement signed with the Government. The service conditions stipulate that not less than 51% of the inpatient bed days shall be offered in the form of standard hospital beds at packaged charges to Hong Kong residents each year. In case of violation of the service conditions, the hospital will be subject to a penalty by the Government, which includes monetary compensation.

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12 The daily charge for admission to a 5-bedded standard ward in the Old Wing of Hospital B was $550 (as at August 2019), and a stay of three days would cost a total of $1,650.

13 It was calculated on the assumption that the charges for low-charge beds were 70% of those for standard hospital beds, i.e. 21,893÷0.7≈$31,276.

2.33 The Government considered that it is difficult for patients choosing low-charge beds to estimate the actual fees before they are admitted to private hospitals because they still have to pay for hospital charges and doctor's fees in addition to the fees for low-charge beds. Hence, the total fees to be paid are still much higher than in public hospitals. For most patients who choose public hospital services due to financial consideration, the policy of low-charge beds has not given them strong financial incentive to switch to private hospital services.

2.34 Moreover, the Government noted that many patients who have chosen private hospital services have insurance coverage. Hence, in choosing healthcare services, they do not regard the charges as the only consideration as long as their insurance policies can cover the fees. On the Contrary, certainty and transparency of charges are crucial. Providing services at packaged charges can improve transparency of charges so that patients can make more accurate estimates, thus giving strong incentive to those who can afford private healthcare services. Compared with low-charge beds, service packages can benefit more members of the public.

2.35 In addition to service packages, the Government noted that it has endeavoured to increase the transparency of private hospital charges and introduced the Voluntary Health Insurance Scheme with a view to encouraging members of the public to switch to private healthcare services. In the Government's view, all these measures can boost patients' confidence in using private healthcare services, and in the long run, help alleviate the burden on the public healthcare system.

3

UTILISATION RATES OF LOW-CHARGE BEDS

UTILISATION RATES OF LOW-CHARGE BEDS IN RECENT YEARS

3.1 The land grant conditions only stipulate that private hospitals should provide adequate low-charge beds while setting no requirement on the utilisation rates.

3.2 The Government will gather information about the utilisation rates of low-charge beds in the two private hospitals to check whether these hospitals have provided adequate low-charge beds in accordance with the land grant conditions. Although there are no requirement for the utilisation rate of low-charge beds in the land grant conditions, the Government will urge the hospitals to find out the reasons, submit improvement proposals and adopt improvement measures in case of low utilisation rates. It will then observe the implementation of proposals to check their effectiveness.

3.3 The utilisation rates of low-charge beds and overall utilisation rates of hospital beds in Hospital A and Hospital B each year from 2014 to 2019 are listed in **Tables 10 and 11** below.

Table 10: Utilisation rates of low-charge beds in Hospital A

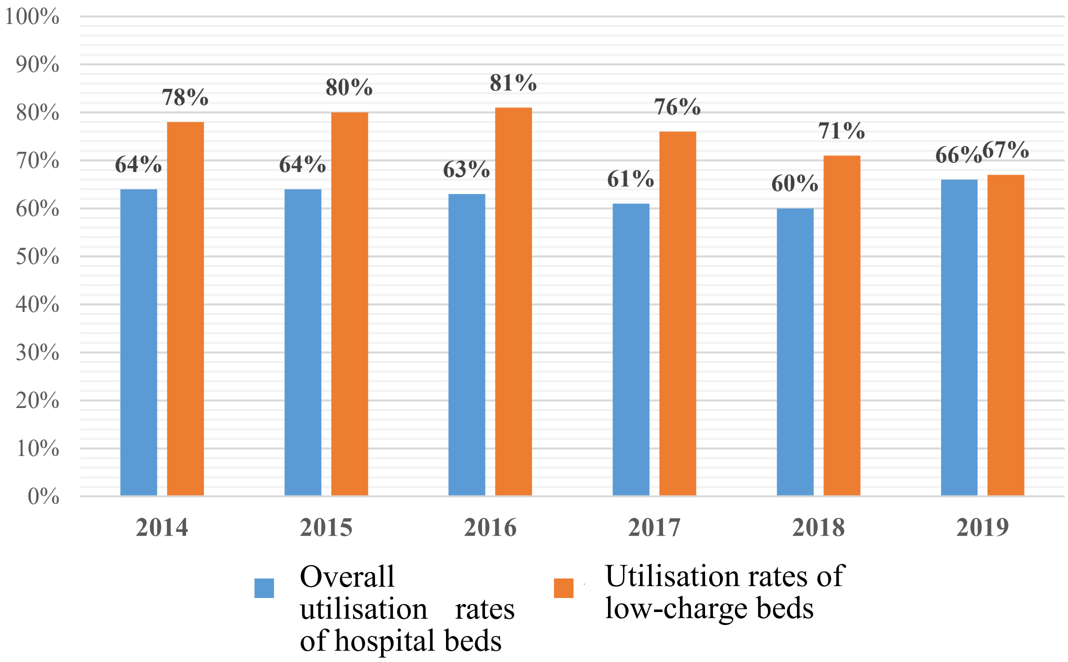
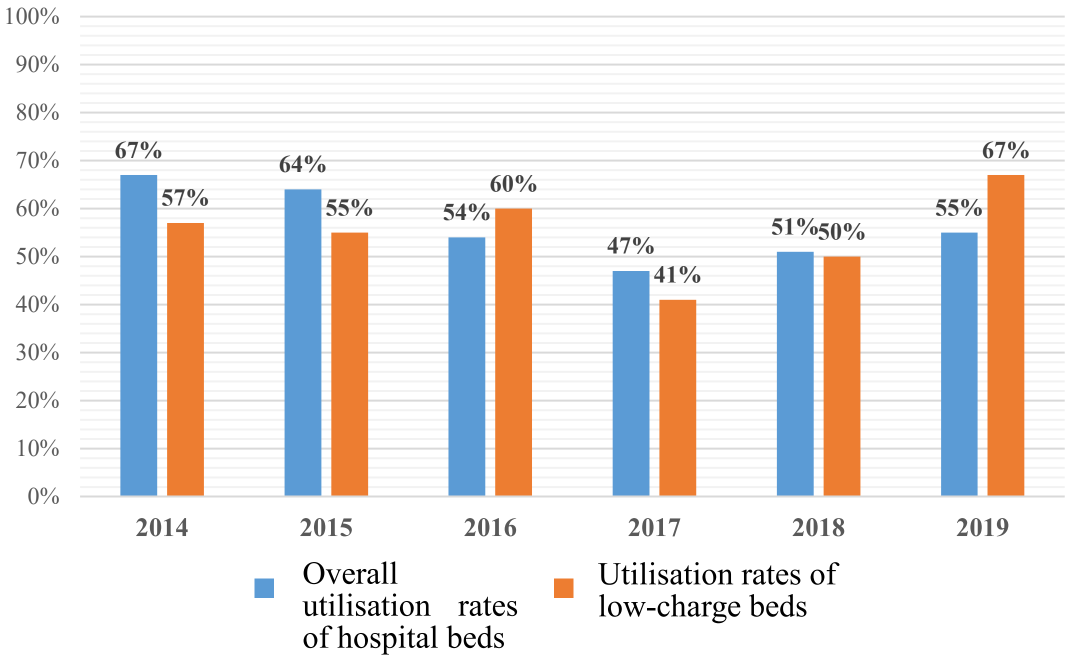


Table 11: Utilisation rates of low-charge beds in Hospital B



3.4 In case the utilisation rates of low-charge beds in the two private hospitals are consistently lower than their overall utilisation rates of hospital beds, the Government will urge the hospitals to find out the reasons and submit improvement proposals. Hospital A had met the aforesaid standards from 2014 to 2019 (see **Table 10** in **para. 3.3**) while utilisation rates of low-charge beds in Hospital B in 2014, 2015, 2017 and 2018 had been lower than its overall utilisation rates of hospital beds (see **Table 11** in **para. 3.3**).

3.5 The Government noted that the utilisation rates of low-charge beds of the two hospitals were higher than the overall utilisation rates of their hospital beds in 2019.

MEASURES TO IMPROVE UTILISATION RATES OF LOW-CHARGE BEDS

3.6 The Government pointed out that there was room for improvement in the utilisation rates of low-charge beds in Hospital B as the relevant utilisation rates had been rather low in the past. In April 2017, the Government asked Hospital B to ascertain the reasons and propose specific measures for improvement. Hospital B undertook to implement the following measures:

- Continue to notify patients about the low-charge bed services at their admission;
- Step up publicity of low-charge bed services in the community;
- Remind the resident and private doctors that they can recommend low-charge beds to their patients;
- Admit patients who have joined the Colorectal Cancer Screening Pilot Scheme[14] to the low-charge beds for the screening; and
- Plan more service packages for day surgeries for patients using low-charge beds.

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[14] In September 2016, DH launched the Colorectal Cancer Screening Pilot Scheme to subsidise colorectal cancer screening for Hong Kong residents in phases. The scheme became a regular arrangement in August 2018 and was renamed as the Colorectal Cancer Screening Scheme.

3.7 Initially, low-charge beds in Hospital B were only offered to surgical patients. Subsequently, Hospital B agreed to the Government's proposal and started to admit medicine and gynaecology patients to low-charge beds in August 2017. Since June 2018, Hospital B has relaxed the age limit for low-charge bed patients from 18 or above to 15 or above.

WHY PATIENTS REFUSED TO USE LOW-CHARGE BEDS

3.8 As the utilisation rates of low-charge beds were lower than the overall utilisation rates of hospital beds in Hospital B between 2014 and 2015, the hospital's appointment centre, as proposed by the Government, started to keep statistical figures on patients' refusal to use such beds and their reasons since December 2016. The relevant information would be included in the monthly reports on utilisation of low-charge beds submitted to the Government.

3.9 According to the statistical figures provided to the Government by Hospital B, the hospital's appointment centre had actively arranged low-charge beds for patients for 3,151 times between December 2016 and November 2017, but nearly all those patients except for four (0.1%) refused it. There was improvement after the Government had proposed actively that Hospital B should adopt measure to raise the utilisation rates of low-charge beds. Nevertheless, as at September 2018, only 6% of the patients were willing to use low-charge beds after being briefed about the services.

3.10 Low-charge beds in Hospital B have been located within the hospital's Old Wing since they were provided. The statistics kept by Hospital B reflect that most patients who refused to use low-charge beds wanted to be admitted to the wards in the New Wing. Hence, in response to the Government's proposal, Hospital B started to provide low-charge beds in the Surgical and Gynaecology Wards in its New Wing on 15 October 2018 (see **Table 3** in **para. 2.17**).

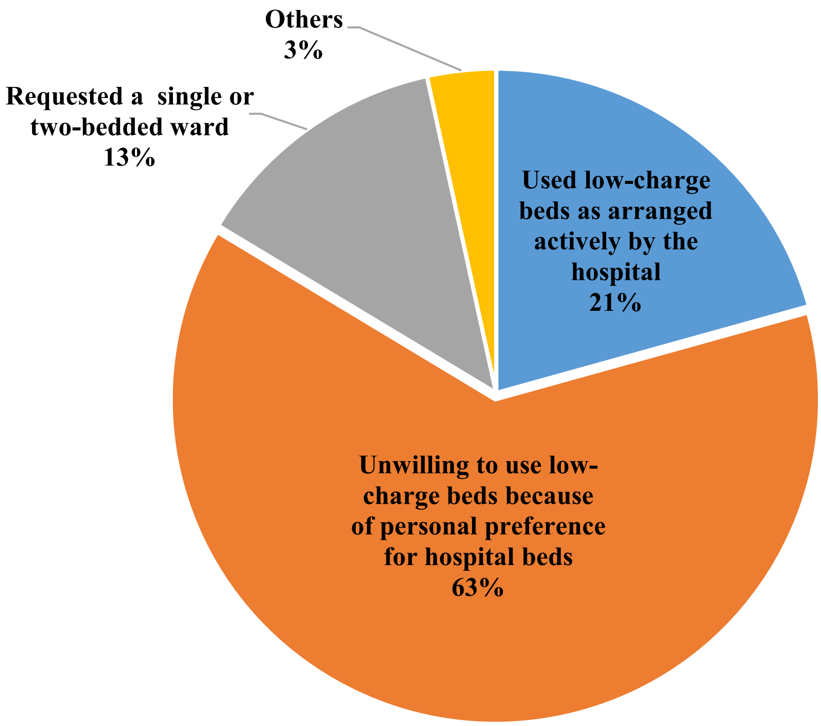
3.11 After providing low-charge beds in the New Wing, the utilisation rates of such beds in Hospital B increased from 54% in October 2018 to 77% in May 2019. However, it should be noted that there were still nearly 80% of patients who refused to use low-charge beds, according to the statistical figures in May 2019[15].

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15 In May 2019, the appointment centre of Hospital B actively arranged low-charge beds in 788 cases, but 625 patients rejected it, representing about 80% of the total number of cases.

3.12 About 60% of patients did not want to use low-charge beds because of their "preference for hospital beds" while some 10% of them requested a single ward or two-bedded ward because they had medical insurance coverage. 3% of patients rejected the arrangements because low-charge beds were not available in the specialist wards they were admitted to or they needed to be segregated for treatment. The statistical figures are provided in **Table 12**.

Table 12: Statistical figures on Hospital B's active arrangements for low-charge beds (May 2019)



3.13 The Government noted that patients have their own considerations in deciding whether to use low-charge beds. Patients who have purchased medical insurance policies can choose the class of wards according to their needs and this may affect their choice. Moreover, although low-charge beds are cheaper than ordinary hospital beds, there are still other fees that patients need to pay.

3.14 We have learned from the two private hospitals that some patients were reluctant to use low-charge beds as they were concerned about being labelled, or misunderstood that the equipment and services of such beds were of lower standards. Some patients were discontented about being arranged low-charge beds and requested to be admitted to other wards.

3.15 Furthermore, the two private hospitals explained that patients' clinical condition may also affect arrangements for low-charge beds. Patients who need special medical equipment cannot be admitted to the low-charge beds in wards that are not installed with such equipment.

PUBLICITY AND PROMOTION OF LOW-CHARGE BEDS

3.16 According to DH, when it inspects the low-charge bed services in the two private hospitals, it would check if the hospitals have informed patients about low-charge beds and provide adequate notices and leaflets about the services (see **para. 2.15**).

3.17 DH noted that during its previous inspections, notices and leaflets providing information on the admission requirements and fees for low-charge beds were found at the waiting hall, admission section and nurse posts on relevant floors of the two private hospitals. Detailed fee schedules of the services were available at the admission section. Relevant information has also been uploaded to the hospitals' websites.

3.18 We conducted site inspections on the two private hospitals in July and August 2019. Below are our observations.

Hospital A

3.19 Leaflets on low-charge beds were available at the admission counter at Hospital A's lobby (see **Figure 4**). On the notice board was the list of charges indicating that "subsidised wards" (i.e. wards with low-charge beds) were available, but the words were too small to be legible (see **Figure 5**).

Figure 4: Leaflets on low-charge beds at Hospital A's admission counter

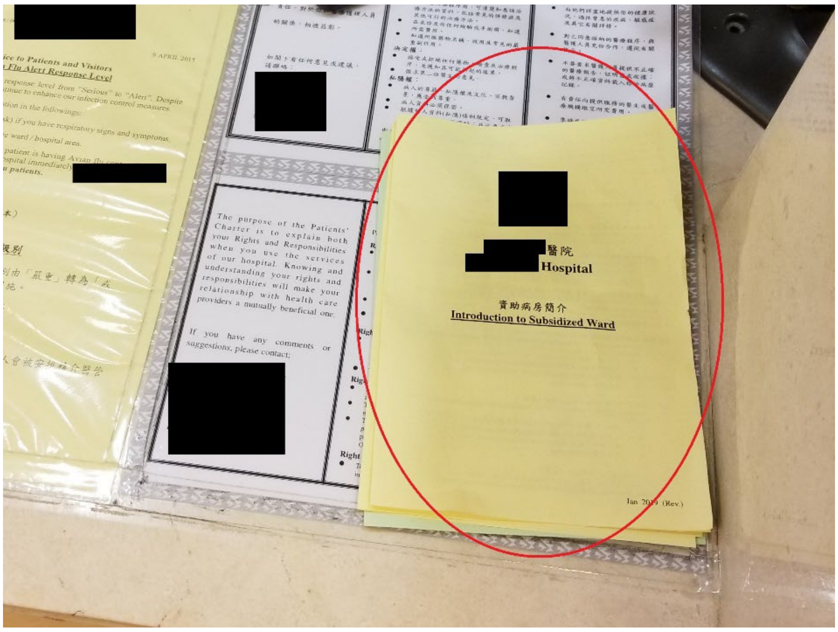


Figure 5: List of charges on Hospital A's Notice Board
(Information about low-charge beds inside the red circle)



有關資助病房簡介 本院另設有資助病房，每天房租為港幣一百二十元正，包括早、午、晚三餐基本膳食。其醫療雜項收費一般比標準房的收費相對較低。住院時，須繳交現金或信用咭港幣七十元作按金。如需要，陪人床每天收費為港幣一百四十元正。
資助日間服務的病床收費為港幣九十六元正，包括一膳基本膳食。
另有全面資助護養病床二十張，入住須由醫務社工評估轉介。

Subsidized Wards' Information The Subsidized Wards' daily bed charge will be HK$120 per day, which includes the provision of 3 basic meals (breakfast, lunch and dinner). Generally, the medical and associated charges for subsidized wards are lower than that of the standard ward. Initial deposit of HK$7,000 in cash or by credit card is required during admission. Extra bed charge of HK$140 will be charged for companion of patient.
Subsidized Day Case bed charge will be HK$96, which includes one basic meal.
There are 20 fully subsidized geriatric beds. Admission requires screening by medical social worker.

Hospital B

3.20 Leaflets on low-charge beds were available at a number of places within Hospital B's Main Block (see **Figure 6**). Notices were also posted at conspicuous locations of admission office to inform patients of the admission requirements and charges of low-charge beds (see **Figure 7**). Moreover, signs at the Main Block indicated which units accommodate low-charge beds (see **Figure 8**).

Figure 6: Leaflets on low-charge beds placed inside Hospital B



Figure 7: Notices about low-charge beds in Hospital B

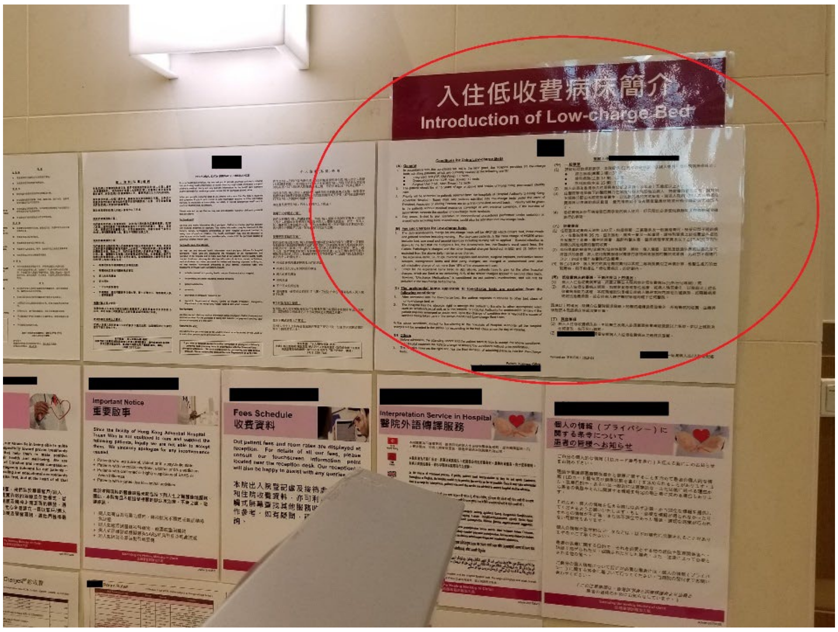


Figure 8: Sign in Hospital B's New Wing



Information on Websites of The Two Private Hospitals

3.21 The Government pointed out that Hospital A and Hospital B have already uploaded information about low-charge beds on their websites for public information (see **para. 3.17**). Nevertheless, we noticed that both hospitals did not provide information or hyperlink on the main page of their websites about low-charge beds[16].

3.22 On Hospital A's website, links to information on different classes of wards including subsidised wards (i.e. wards accommodating low-charge beds) were provided in a pop-up which will appear only after clicking "Ward Charges" on the page of "Service fees". On Hospital B's website, the link to information about low-charge beds was on the page of "Admission Notice/Fees".

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16 The situation as at 30 September 2019.

4

Arrangements for Referring Public Hospital Patients to Use Low-charge Beds

GUIDELINES ON REFERRING PUBLIC HOSPITAL PATIENTS TO USE PRIVATE HEALTHCARE SERVICES

4.1 In 2012, HA established general guidelines on referring public hospital patients to use private healthcare services with reference to the corruption prevention guides issued by the Independent Commission Against Corruption. The general guidelines aim to remind frontline officers how they could refer patients to private healthcare services in a fair and impartial manner.

4.2 Moreover, in 2014, HA set out the procedures for handling clinical services provided by the private sector at low charges or discount rates. Under the relevant mechanism, HA would consider such factors as the patients' needs, resources involved and risk assessment in deciding whether to employ such services provided by the private sector.

4.3 HA welcomed the provision of clinical services by the private sector to HA patients at low charges or discount rates. Nevertheless, HA would not proactively promote such services so as to avoid giving an impression or misunderstanding of benefit transfers or creating unfairness. HA would only suggest the service providers to find other channels to promote their services.

4.4 Hospital A and Hospital B had respectively written to the public hospitals of various clusters to invite referrals of patients to use their low-charge beds. Hospital B has stated in the admission conditions of low-charge beds that priority will be given to

patients referred by the hospitals under HA. In April 2015 and January 2016, Hospital B wrote to HA again to invite referrals of patients.

4.5 HA confirmed that some public hospitals had received such letters from Hospital A and Hospital B. However, as low-charge bed services provided by these hospitals are covered by the aforesaid guidelines, public hospital staff would not actively make referrals but would only do so upon receiving requests from patients. There is no mechanism in place for making standing arrangements for referrals of patients to use low-charge beds in private hospitals.

4.6 The Government, on the other hand, indicated that it is one of the private hospitals' promotional measures to write to public hospitals to provide information about their low-charge bed services, so that public hospital patients who are interested in using private hospital services will be aware of such alternatives. Whether patients will use such services depends on whether they can afford the services and their preferences. At present, the Government does not gather figures about public hospital patients who have switched to low-charge beds in the private hospitals.

REFERRING PUBLIC HOSPITAL PATIENTS TO LOW-CHARGE BEDS DURING INFLUENZA SURGES

Relevant Land Grant Conditions

4.7 The land grant conditions mentioned in **paragraph 2.7** stipulate that DH and Hospital A and Hospital B may utilise the low-charge beds by mutual agreement.

4.8 According to the Lands Administration Office Instructions of LandsD, D of H and HA's Chief Executive may utilise the low-charge beds in accordance with the land grant conditions provided that the patients using such beds shall not be chronic cases and the Government shall pay the fees not exceeding the amounts stipulated in the land grant conditions.

4.9 The Government noted that depending on the situation, HA can establish agreements with the two private hospitals direct on the use of low-charge beds in accordance with the land grant conditions. The agreements would cover when to activate the agreement, eligibility of patients, arrangements for transfers and charges. The Government will advise HA on whether the agreements are in line with the relevant land grant conditions.

Agreements on Transfer

4.10 Although HA indicated that it would not actively refer patients to use low-charge beds (see **paras. 4.3 and 4.5**), it signed a five-year agreement with Hospital A in 2016 for referring public hospital patients suffering from non-infectious diseases to use the low-charge beds in case of any outbreak of infectious diseases. Subsequently, in 2017 and 2018, HA and Hospital A signed letters supplementary to the agreement[17] to extend the coverage so that referrals of patients could also be made during influenza surges and the excessive demand for public hospital beds could be eased. In January 2018, HA also signed a five-year agreement with Hospital B on referrals of patients to its low-charge beds in case of outbreaks of infectious diseases or excessive demand for services.

4.11 According to the relevant agreements, patients referred only needed to pay a fee equivalent to the daily hospital charges of public hospitals (i.e. $120) (see **Note 1** in **para. 1.2**), and the other fees would be borne by HA and be calculated based on the standards of low-charge beds (see **paras. 2.7 and 2.22**). The maximum amount of fees to be borne by the Government for each patient would be $45,000, and when the fees charged for a patient reached half of this amount, HA should be informed and provided with relevant information. HA would then consider whether the patient should be transferred back to public hospitals.

4.12 During the specified influenza surges, the private hospitals were required to reserve a certain number of low-charge beds for referrals from HA. Under the agreements, Hospital A should reserve 48 low-charge beds while Hospital B should reserve half of its low-charge beds (i.e. 30 beds). HA noted that on operation front, the two private hospitals agreed that HA could inform them one day in advance of the number of beds to be reserved so that they could make the arrangements.

4.13 Under the relevant agreements, HA could, during the influenza surges, referred those public hospital patients:

- whose estimated length of stay would be less than seven days;

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17 HA and Hospital A signed letters supplementary to the agreements on referrals of patients in July and December 2017 and December 2018 to cover the 2017/18 summer and winter surges of influenza, and the 2018/19 winter surge of influenza respectively.

- who are recovering after surgery; and/or who are orthopaedic patients; and/or non-emergency patients who are recovering; and/or patients in conditions that HA and the private hospitals regarded as stable;

- who are not suffering from any active infectious diseases and/or disease which are infectious;

- who do not require urgent or frequent physiotherapy.

4.14 HA's frontline staff would identify suitable patients and refer them to private hospitals upon obtaining their consent. In order not to increase the burden of frontline staff, HA would not require them to record patients' intent to be referred and their reasons for refusal.

Figures on Referrals

4.15 The figures on HA's referrals of public hospital patients to use the low-charge beds in Hospital A and Hospital B during influenza surges are listed in **Table 13** below.

Table 13: Numbers of patients referred to use low-charge beds during influenza surges

Influenza Surges	Period	Hospital A		Hospital B	
		Patients referred	Length of Stay	Patients referred	Length of Stay
2017 Summer surge	July to September 2017	35	147	-	-
2017/18 Winter surge	January to April 2018	24	103	1	7
2018/19 Winter surge	January to May 2019	25	113	1	7
Total number of patients referred		**84**		**2**	
		86			

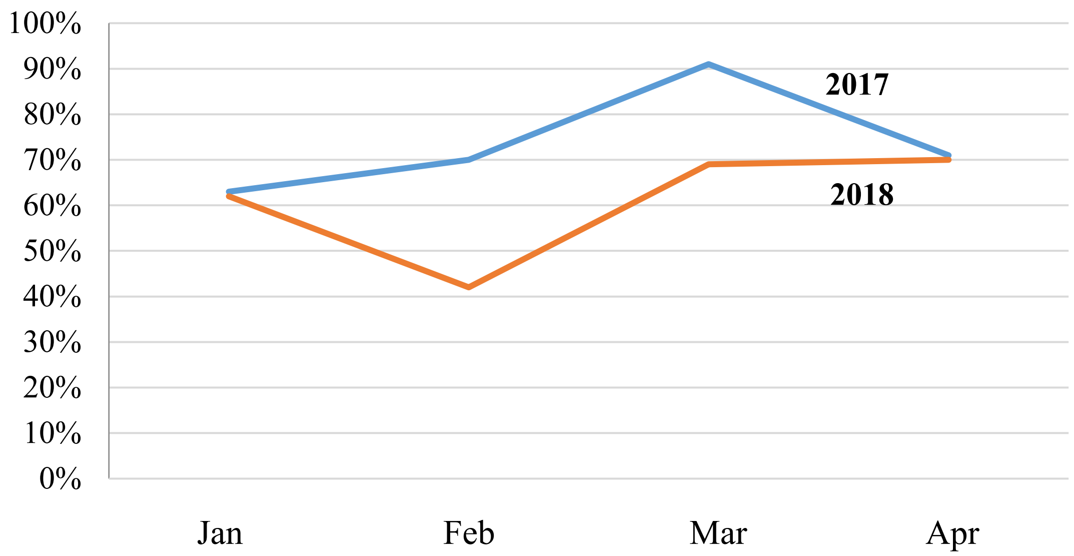
4.16 **Table 13** shows that only a small number of public hospital patients were referred to the low-charge beds: Hospital A took only 24 to 35 public hospital patients during three influenza surges while Hospital B took only two patients in total during two influenza surges.

4.17 Take the 2017 summer surge of influenza as an example, the referral arrangements were activated for 41 days in total under the agreement[18]. Given that 48 low-charge beds were reserved, the total number of inpatient bed days of low-charge beds available in Hospital A would be 1,968. In other words, if each patient had stayed for less than seven days, Hospital A could accept at least 281 public hospital patients. Nevertheless, the public hospitals referred only 35 patients to Hospital A and the total number of inpatient bed days for low-charge bed was 147 days, which is merely 7.5% of the available days for the low-charge beds in that hospital.

4.18 Both Hospital A and Hospital B indicated that the numbers of referrals from public hospitals were far below expectation. As the two private hospitals had agreed to reserve a certain number of low-charge beds for referrals (see **para. 4.12**), and the actual numbers of referrals were rather small, the utilisation rates of low-charge beds during the period that the referral arrangements were activated were even lower than usual (the period when the agreements were not activated).

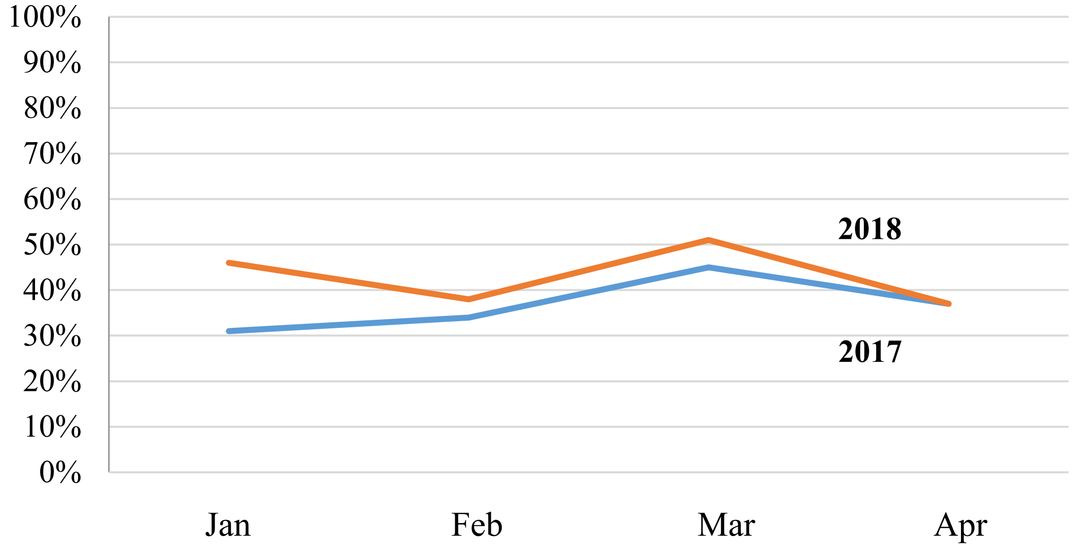
4.19 **Tables 14 and 15** compare the utilisation rates of the low-charge beds in the two private hospitals between January and April 2018 (during which the referral arrangements were activated in the 2017/18 winter surge of influenza) with those of the same period in 2017 (where there was no referral agreement).

Table 14: Utilisation rates of low-charge beds in Hospital A between January and April in 2017 and 2018



[18] The agreement was valid between 26 July and 4 September 2017.

Table 15:：Utilisation rates of low-charge beds in Hospital B between January and April in 2017 and 2018



4.20 **Tables 14 and 15** show that during the 2017/18 winter surge of influenza between January and April 2018 when the referral agreements were activated, the utilisation rates of low-charge beds in Hospital A were noticeably lower than those of the same period in 2017. As for Hospital B, the utilisation rates of the aforesaid winter surge were similar to those of the same period in 2017.

4.21 During the 2017/18 winter surge of influenza, Hospital B took only one patient. Subsequently, after deliberation with HA, Hospital B would only arrange adequate low-charge beds to accommodate referrals from public hospitals upon receiving notification about the number of patients during the 2018/19 winter surge.

Reasons for Low Numbers of Referrals

4.22 HA admitted such referral agreements were not effective and explained that the arrangements required not only the patients' consent but also their meeting specific clinical conditions (see **para. 4.13**).

4.23 HA considered the strict criteria for referral necessary to ensure patients' safety and avoid the need to transfer patients back to the public hospitals when their clinical conditions deteriorated. Thus, HA and private hospitals agreed that only patients in stable clinical conditions could be referred. In the course of selection, frontline staff found that most patients were not suitable for referrals because of their

clinical conditions. In the end, among those 86 patients referred (see **Table 13** in **para. 4.15**), 12 had to be transferred back to public hospitals as their conditions deteriorated.

4.24 HA further noted that while its arrangements for low-charge beds aim to be a trial programme meeting urgent demands, the modes of delivering healthcare services in public and private hospitals are different. Public hospital patients who need services by various professionals and specialists are usually not suitable for referring to private hospitals.

Improvement Measures for Referral Agreements

4.25 There is no upper limit of age in the criteria for patient under the referral agreements for influenza surges (see **para. 4.13**). Nevertheless, Hospital A initially accepted only patients under the age of 70 (while Hospital B had not set any upper limit). Among the public views gathered (see **para. 1.6**), a public hospital frontline doctor noted that only very few patients could actually be referred because there were very strict criteria for selection of patients regarding their clinical conditions.

4.26 The minutes of the meeting between HA and Hospital A in February 2019 reveals that Hospital A had declined the referral of a patient diagnosed with slow heart rate on the day of transfer because the cause of the problem could not be confirmed. The referral of another patient was also cancelled on grounds of a mild fever on the day of transfer.

4.27 Regarding the above, HA noted that there must be close communication and mutual agreement with the private hospital concerned for every referral of patients. Hence, no private hospitals (including Hospital A and Hospital B) had refused to admit public hospital patients during the previous influenza surges.

4.28 Between September 2018 and February 2019, HA had met with Hospital A twice to discuss the possibility of relaxing the criteria for patients' clinical conditions so that more patients could be referred and frontline staff could have more flexibility in selecting suitable patients.

4.29 The relevant minutes of meetings reveals that both parties agreed to relax the criteria for referral of patients by removing the age limit of 70, adding time slots for physiotherapy, allowing referrals of patients who are of very slow heart rate but in stable conditions and those who are bed-ridden but need only basic nursing care (such as

changing of diapers). In March 2019, both parties further agreed to extend the coverage to patients from rehabilitation hospitals.

4.30 Moreover, during the aforesaid meetings, HA and Hospital A confirmed some restrictions regarding the clinical conditions of patients referred. For example, patients having a fever cannot be referred until the cause has been confirmed. Dementia patients showing disruptive behaviour (such as yelling and running around) should also not be referred because the private hospital could not use physical restraint on patients.

Manpower and Administrative Arrangements for Patients Referral

4.31 Among the public views we received, a frontline staff member from a public hospital revealed to us the inadequacy in manpower to select suitable patients for referrals and unavailability of staff to make the selection during weekends. Moreover, in addition to consent from patients, the private hospitals requested public hospitals to complete various forms, thus creating extra administrative and clerical work.

4.32 In response, HA revealed that frontline staff in public hospital would deal with the selection work on Mondays to Fridays because private hospital staff are not available for liaison with public hospitals regarding referral arrangements during weekends. HA explained that in selecting suitable cases, its staff have to explain the details to patients and their family, prepare relevant documents (including summary of patients' discharge, referral form and patients' consent), communicate with private hospitals before referring patients, arrange for non-emergency ambulance and post-discharge follow-up.

4.33 As to whether the administrative procedures could be streamlined, HA explained that referrals of patients must be arranged carefully to ensure patients' safety, and it takes much time to select suitable patients and explain the details to patients. Communication between frontline staff and patients is necessary for assisting patients to decide whether they would accept the referral arrangements.

OTHER FEASIBLE MEASURES TO BETTER UTILISE LOW-CHARGE BEDS

4.34 During our interviews with Hospital A and Hospital B, both hospitals indicated that they welcomed HA's referrals of patients who are waiting for treatments

at public hospitals to use their low-charge beds. In fact, the Government and HA have in recent years introduced a number of public-private partnership programmes to encourage the public to use the private healthcare services by providing subsidy to eligible patients. One of the examples is Colorectal Cancer Screening Scheme.

4.35 On the feasibility of using low-charge beds for public-private partnership programmes, HA noted that the existing partnership programmes are mostly for outpatients receiving one-time treatment, suffering from chronic or episodic illness, or long-term inpatients who require infirmary care. They are not suitable for referrals to low-charge beds in the private hospitals.

4.36 HA admitted that the efforts put into referrals of patients during influenza surges have not paid off and the effectiveness has been low. Public hospitals have put considerable manpower and resources on selection of patients for referrals, putting a heavy burden on frontline medical personnel. But only a small number of suitable patients agreed to be referred. It has not been cost-effective.

4.37 HA emphasised that it is the private hospitals' responsibility to effectively utilise their low-charge beds, and the monitoring of such arrangements is not within the ambit of HA. When HA considers collaborating with DH and the private hospitals on extensive use of low-charge beds, the key factor would be whether such arrangements could be applied to public hospital patients in general. HA's considerations include operational feasibility, safety and effectiveness of treatment, acceptability of patients, effectiveness of relieving the burden of public healthcare system.

4.38 HA reiterated that the operation modes of delivering healthcare services in public and private hospitals vary greatly. While private hospitals admit only non-chronic patients and there is a limit on the patients' length of stay, public hospitals have many chronic patients. Based on the experience of referring patients during influenza surges, most patients were not suitable for referral but the frontline staff had to spend considerable time on administrative work and the selection involved many medical professionals. In some cases, the patients suffered unnecessarily because they had to be transferred back to public hospitals when their condition deteriorated, and that had also put extra burden on frontline staff. Hence, HA considered it inappropriate to set up a mechanism for making standing arrangements for referrals of patients to low-charge beds.

5

OUR COMMENTS AND RECOMMENDATIONS

OVERVIEW

5.1 When the Government granted land to the two private hospitals for their developments at a nominal rent of $1,000, it included the requirement for low-charge beds in the land grant conditions, with the intention to convey the message that private hospitals with land granted at a concessionary land premium had to shoulder certain social responsibility and provide services to patients in need.

5.2 In fact, the Government has been proactively promoting the development of private hospitals and encouraging people who can afford higher charges to use private healthcare services so as to alleviate the burden on public hospitals. The low-charge beds in the private hospitals provide incentive for patients who can afford private healthcare services, thus enabling public hospitals to allocate more resources on serving those in need.

5.3 As at December 2019, the two private hospitals provided a total of 164 low-charge beds. The number of low-charge beds may not appear to be high, but if each patient stays for two to four days on average and the admission rates of low-charge beds reach 80%, these beds can handle about 12,000 to 24,000 attendances of patients each year. Optimising the use of low-charge beds can help alleviate the burden of the healthcare system overall and complement with the Government policy of encouraging the use of private healthcare services (see **para. 5.2**).

5.4 Nevertheless, before Aud published the Report in 2012, the requirements for low-charge beds under the land grant conditions for Hospital A and Hospital B had not been effectively implemented (see **para. 2.12**). According to the Report, the utilisation rate of Hospital A's low-charge beds was only 1% in 2008 and the rates between 2009 and 2011 ranged from 23% to 45%.

5.5 We are pleased to note that the Government has subsequently stepped up its monitoring of these hospitals' compliance with the land grant conditions with regard to provision of low-charge beds. Besides, it has recommended that measures be introduced to improve the utilisation rates of low-charge beds in the two hospitals (see **paras. 2.13-2.16**). In 2017, the Government further requested that Hospital B introduce measures to improve the utilisation rates of the hospital's low-charge beds, which include relaxation of the age limit of low-charge bed patients and provision of low-charge beds in its New Wing (see **paras. 3.7 and 3.10**).

5.6 **Tables 10 and 11** (see **para. 3.3**) show the significant increase in the utilisation rates of low-charge beds in the two hospitals from 2014 to 2019 compared with the rates before Aud published the Report (see **para. 5.4**). We recognise and appreciate the Government's positive attitude and efforts in this aspect.

5.7 That said, our direct investigation has revealed room for further improvement in the Government's promotion of the use of low-charge beds. The investigation has also found that the referral arrangements between HA and the two private hospitals during influenza surges have been ineffective.

5.8 Overall, this Office has the following observation and comments.

(I) GOVERNMENT SHOULD MONITOR AND REVIEW POLICY OF LOW-CHARGE BEDS

5.9 The Government noted that as the land grant conditions for the two private hospitals do not specify the conditions on the use of low-charge beds (including their utilisation rates), it is difficult to enforce the relevant requirements. Moreover, provision of low-charge beds had been ineffective for encouraging members of the public to go to private instead of public hospitals. After giving due consideration and reviewing the policy of low-charge beds, the Government decided in January 2011 to introduce the requirements for service packages to replace those for low-charge beds when renewing the land leases with private hospitals (see **paras 2.30-2.35**).

5.10 As regards the Government's opinion in the above paragraph, we have to point out that the requirements for low-charge beds had not been effectively enforced when ExCo made the decision in January 2011, and the utilisation rates of low-charge

beds at that time were very low. Nevertheless, subsequent to the publication of the Report by Aud in 2012, the Government has stepped up its enforcement of the requirements. There has been significant improvement in the utilisation of low-charge beds compared with 2011 or before (see **paras. 5.4-5.6**). Given that it is still decades before the land leases for Hospital A and Hospital B expire in June 2047 and June 2060 respectively (see **paras. 2.6 and 2.8**), we consider that it is worth reviewing the Government's policy of low-charge beds before the land leases concerned expire.

5.11 Although the Government stressed that provision of low-charge beds has not helped much in encouraging people to switch to private hospitals and alleviate public hospitals' burden, we still find those low-charge beds useful in that they provide incentive to people who can afford private healthcare services and help alleviate the burden of public hospitals under HA when necessary. Furthermore, inclusion of the requirements for low-charge beds has given a clear indication to the private hospitals concerned that land grants at concessionary premiums come with social responsibility. Despite FHB's and DH's claim that it is difficult to implement the requirements for low-charge beds, there were marked improvements in the utilisation rates of low-charge beds after the Government strengthened the enforcement of the requirements. In fact, the two private hospitals have been cooperative in adopting measures to improve the utilisation rates (see **paras. 5.5-5.6**). That means proper implementation of the requirements is not impossible.

5.12 It is true that low-charge beds are no panacea for the imbalance between the public and private healthcare sectors. Nevertheless, the policy of low-charge beds provides incentive for people who can afford private healthcare services and is complementary to service packages and voluntary medical insurance introduced in recent years. Service packages and low-charge beds are not contradictory, and there is no need for the Government to choose between them. One possible option is to let private hospitals offer low-priced service packages using their low-charge beds.

5.13 Although the Government noted that low-charge beds could not provide any financial incentive for patients to switch to the private healthcare services (see **para. 2.33**), we must point out that charges for private healthcare services (whether they are offered with low-charge beds or service packages) are certainly much higher than those for the public healthcare services. Both low-charge beds and service packages target not at the grassroots but the better-off people, and they are intended to encourage those people to use private healthcare services so that public hospitals can allocate more resources on serving the grassroots. For patients who have medical insurance, their

insurance coverage usually has an upper limit. If patients choose to use low-charge beds, their insurance coverage might cover most of the costs and that will give them incentive to switch to private healthcare services.

5.14 In view of the above, we consider that low-charge beds do have their value, and provision of service packages is still at an initial stage. Given that the two private hospitals are still required to offer low-charge beds for more than 20 years before their land leases expire, the Government should continue to monitor the use of low-charge beds, and proactively explore ways to better utilise those beds and revisit the relevant policy when reviewing that of service packages.

(II) HA SHOULD BETTER UTILISE LOW-CHARGE BEDS TO DIVERT PATIENTS TO PRIVATE HEALTHCARE SECTOR

5.15 At present, there is great imbalance between public and private healthcare systems. While the public hospitals under HA are taking up 90% of the hospitalisation cases, the private healthcare sector handle only the remaining 10%. The heavy workload of public hospitals has been unequivocal especially during influenza surges when hospital beds are fully occupied.

5.16 In recent years, the Government has attempted to address such imbalance by encouraging those who could afford higher charges to go to the private sector. In our view, one of the Government's objectives for low-charge beds is to echo the policy of encouraging people to use private healthcare services so as to relieve the long-term burden suffered by public hospitals. As the highest utilisation rates of low-charge beds in Hospital A and Hospital B have been 70% to 80%, the two hospitals still have the capacity for referrals from public hospitals.

5.17 While we agree that HA is under no obligation to monitor and improve the utilisation of low-charge beds (see **para. 4.37**), optimising those beds can help alleviate the burden of public hospitals and spare more resources for patients in need. We consider the agreements between HA and Hospital A and Hospital B on referrals of patients to low-charge beds during influenza surges (see **para. 4.10**) a positive and sensible step. This direct investigation has revealed the following areas for improvement in HA's use of low-charge beds to divert patients to the private healthcare sector.

(1) Introducing Measures to Address the Ineffectiveness of Referral Agreements during Influenza Surges

5.18 Information about HA's referrals of patients during influenza surges reveals the ineffectiveness of the referral arrangements, under which only a few patients had been referred. In two influenza surges, Hospital B had accepted only two public hospitals patients (see **Table 13** in **para. 4.15**). Under the agreements between the two private hospitals and HA, the hospitals were required to reserve a certain number of low-charge beds for referral arrangements. Due to the very small number of referrals, many of the low-charge beds reserved had been idled, which is in contrary to the original intention of such arrangements. During the period when the referral arrangements were activated, the utilisation rates of low-charge beds in Hospital A were lower than those of the same period in the previous year (see **paras. 4.18-4.20**).

5.19 HA's explanation for the rather small number of referrals was that strict criteria for referral were necessary to ensure patients' safety. HA and the two private hospitals agreed that only patients in stable clinical conditions could be referred. Previously, frontline staff found that most patients were not suitable for referral (see **paras. 4.22-4.24**). Relevant information reveals that public hospitals would mainly refer patients who were recovering or in stable conditions (see **para. 4.13**). Yet, among those 86 patients referred, 12 had to be transferred back to public hospitals due to deterioration in their clinical conditions (see **para. 4.23**).

5.20 We find it necessary that HA investigate why patient referrals during the three previous influenza surges have been ineffective and review the existing arrangements to improve the effectiveness.

<u>Explore Relaxation of Restrictions on Referral of Patients</u>

5.21 According to HA, most of the hospitalisation cases in public hospitals are elderly patients suffering from chronic illness, and those inpatients who receive treatment during influenza surges are mainly patients from surgical and medicine wards. After these patients arrive at the A&E department of public hospitals, doctors have to spend time to examine in detail their condition and arrange medical procedures as laboratory tests and radiography, and then make diagnosis based on the clinical observations and decide on the treatment. Hence, it is difficult for public hospitals to select suitable cases for referral to private hospitals at the time the patients are admitted.

5.22 We understand that it is rather difficult for HA to select suitable cases for referral among emergency cases from the surgical and medicine wards, which are particularly under stress during influenza surges as described in the above paragraph. On the other hand, we are aware that some of the patients in the surgical and medicine wards may need to be transferred to other wards such as convalescence and infirmary wards for continual care or other treatment when their condition becomes stable. We are of the view that HA could explore the relaxation of restrictions on referral of patients (including the 7-day limit of stay), and consider also patients from other wards, such as convalescent/infirmary wards. Beds in those wards can then be used to receive patients for the surgical and medicine wards. The turnover rates of hospital beds could be enhanced, thereby alleviating the burden on the surgical and medicine wards.

Improve and Simplify the Administrative Work of Referrals

5.23 A public hospital doctor revealed to us that public hospitals did not have adequate manpower to select suitable patients for referrals, and they had to cope with the heavy workload brought by the relevant administrative work. Hence, the selection could be only made on weekdays (see **para. 4.31**). In our view, the arrangement of referral is meant to alleviate the burden of public hospitals during influenza surges. If the relevant administrative work is too complicated, it will defeat the purpose of such arrangement and discourage frontline staff from referring patients to use low-charge beds.

5.24 Hence, HA should explore ways to streamline the procedures and simplify the administrative work in selecting patients for referral. Moreover, HA should collaborate with the two private hospitals on improving the flexibility of reservation arrangement to avoid wasting the low-charge beds reserved during the period when the referral agreements are activated.

Consider Making Referral to Use Low-charge Beds a Standing Arrangement

5.25 Currently, HA does not have a standing mechanism for referring patients to use low-charge beds in the private hospitals beyond influenza surges (see **para. 4.5**). HA explained that based on experience gained during influenza surges, the efforts put into referrals of patients were not paid off because the selection process involved a lot of medical professional and administrative work, but most patients were eventually found not suitable due to their clinical conditions (see **paras. 4.36-4.38**).

5.26 Nevertheless, based on our observations in **paragraphs 5.20** to **5.24**, HA should review the arrangements for referrals of patients to enhance the effectiveness and simplify the administrative work instead of leaving it as it is to avoid troubles. We understand that medical personnel are very busy handling a lot of clinical work during influenza surges and they may not have time to select suitable patients for referrals. In our opinion, depending on the effectiveness of referrals in future, HA can proactively explore the feasibility of making standing arrangements for referrals of patient beyond influenza surges, so that they do not need to wait until the public hospitals are already under great pressure. Medical personnel can also have more time to arrange referrals during off-peak seasons and gain experience in making referrals, thus enhancing its overall effectiveness.

(2) HA Should Explore Feasible Ways to Better Utilise Low-charge Beds

5.27 We consider that HA should collaborate with the two private hospitals to explore other feasible measures to better utilise the low-charge beds so as to divert patients from public hospitals, thereby addressing the current imbalance between the public and private healthcare sectors.

<u>Explore Ways to Encourage Public Hospitals Patients Who Are Awaiting Treatment to Use Low-charge Beds</u>

5.28 As HA pointed out, public hospitals handle more chronic patients who are hospitalised for longer periods and require services of various professionals and specialists. Hence, they are usually not suitable for referring to low-charge beds (see **para. 4.38**). That said, public hospitals also handle many cases that do not involve chronic patients such as those patients awaiting to be admitted for one single surgery.

5.29 According to HA, public hospitals would arrange fewer appointments for inpatients to receive treatment during influenza surges so as to reserve more manpower and resources for emergency cases. Nevertheless, influenza surges usually last for several months, public hospitals could not suspend arrangements for all those patients. Public hospitals will have to clear outstanding cases accumulated after influenza surges as well. We, therefore, consider that HA should explore ways to divert these non-emergency cases of patients who are in stable conditions to use low-charge beds and undergo the necessary surgery.

5.30 We recommend that HA collaborate with the two private hospitals to explore ways to encourage patients who have made appointments or are waiting to receive treatment to use the low-charge beds in the private hospitals so as to alleviate the burden of public hospitals. For example, the private hospitals can offer more concessionary terms or provide low-priced service packages to public hospital patients who agree to use low charge beds.

5.31 It is true that compared with the services of public hospitals, charges for using low-charge beds in private hospitals are still much higher. Nevertheless, for people who can afford higher charges, using low-charge beds and receiving treatment in private hospitals can spare the waiting and offer an environment less crowded, which can be appealing to those patients and might as well alleviate the burden of public hospitals.

<u>Explore the Feasibility of Referring Patients to Low-charge Beds under Public-private Partnership Programmes</u>

5.32 At present, Hospital B uses its low-charge beds to offer services to patients receiving subsidies under the Colorectal Cancer Screening Scheme, which is a public-private partnership programme under DH (see **para. 3.6**). We consider that HA can take into account the demands for public hospitals' services, and examine which items of hospitalisation are suitable for offering subsidies to patients to use low-charge beds and receive treatment in private hospitals under public-private partnership programmes.

5.33 HA noted that the existing public-private partnership programmes are mostly for outpatients or patients requiring infirmary care (see **para. 4.35**) and, therefore, do not need to engage low-charge beds. That said, as HA will offer subsidies to patients in other public-private partnership programmes, using low-charge beds can perhaps reduce the cost for such subsidies. Moreover, the two private hospitals have also indicated that they welcome HA's referrals of patients to use their low-charge beds (see **para. 4.34**).

5.34 HA worries that active participation in promoting private healthcare services may give the false impression or misunderstanding of transfer of benefits (see **para. 4.3**). In our view, a transparent mechanism and clear guidelines for frontline staff should suffice to remove such doubts. Besides, it is for the patients to decide whether to use low-charge beds. In the long run, HA can invite other private hospitals

to joint partnership programmes in various forms to create competition and let the patients make their choices.

(III) THE GOVERNMENT SHOULD EXPLORE WAYS TO FURTHER PUBLICISE USE OF LOW-CHARGE BEDS

5.35 Since we declared the launch of this direct investigation in July 2019, the public responses show that many people including private medical practitioners are not aware of low-charge bed services. We consider that the Government can further publicise such services and improve the utilisation rates by addressing the following aspects.

(1) Strengthening Promotion of Low-charge Beds among Public Hospital Patients

5.36 DH noted that as the Government department responsible for monitoring private hospitals and assisting in the enforcement of land grant conditions, it should not be assisting private hospitals in the publicity or promotion of their services (including the low-charge bed services) to avoid conflicts with its role as the monitoring authority or confusion that the public may have about its function. We should point out that provision of low-charge beds originated from the land grants to the two private hospitals due to the concessionary premiums offered, and therefore, those beds involve public resources and are different from commodities and services provided by ordinary private organisations. Hence, the Government should provide the public with sufficient information about low-charge beds.

5.37 During its inspections, DH will check whether the two private hospitals have informed patients about the low-charge bed services (see **para. 3.16**). Both most of the patients that private hospitals engaged are those who have already planned to be admitted to these hospitals rather than people who have not considered using private healthcare services. In our view, the Government could use various channels to step up its promotion of low-charge beds among members of the public, such as putting up posters or notices in public hospitals under HA to provide information about the low-charge beds. It should also proactively explore other means to make low-charge beds more appealing to patients who can afford higher charges so that they would be encouraged to use private healthcare services. For example, the Government could suggest that private hospitals offer low-priced service packages using their low-charge beds.

(2) Encouraging Hospital B to Provide More Low-charge Beds in Its New Wing

5.38 In deciding whether to use low-charge beds, patients have their own considerations. Given that the low-charge beds are of the same standards as the standard wards' in private hospitals and the services provided are the same, patients should generally be inclined to choose the low-charge beds. Nevertheless, in four of the six years between 2014 and 2019, the utilisation rates of low-charge beds were lower than the overall utilisation rates of Hospital B's hospital beds (see **Table 11 in para. 3.3**).

5.39 Low-charge beds in Hospital B are located in the hospital's Old Wing since the hospital started to provide such services. In fact, most patients of Hospital B refused to use the low-charge beds because they wanted to be admitted to the wards in the New Wing. Although the hospital had agreed to the Government's proposal and started to provide low-charge beds in the Surgical and Gynaecology Wards in its New Wing in 2018, most of its low-charge beds are still in the Old Wing. It may be the reason why patients are less inclined to use the low-charge beds in Hospital B.

5.40 We consider that the Government can discuss with Hospital B on further increasing the number of low-charge beds in the New Wing with a view to attracting additional patients to use those beds.

(3) Recommending Private Hospitals to More Actively Publicise Their Low-charge Beds and Improve the Provision

5.41 The two private hospitals have provided information on low-charge beds in their main blocks, but we found that the fonts used in the relevant notices in Hospital A are so small that they could hardly be read (see **Figure 5 in para. 3.19**), and the websites of these hospitals do not provide information about low-charge bed services (see **paras. 3.21-3.22**). In our view, the Government should discuss with the private hospitals whether they can use their websites or other channels to enhance publicity of the low-charge beds. They can follow the practice of car parks to display the number of available low-charge beds in real time at the hospital lobby as well as releasing regularly the utilisation rates of such beds.

5.42 Moreover, some patients might be reluctant to use low-charge beds because they are concerned about being labelled, or they misunderstand that the equipment and services of such beds are of lower standards (see **para. 3.14**). The signs

in the Main Block of Hospital B show clearly which wards accommodate low-charge beds (see **Figure 8** in **para. 3.20**). The Government should suggest that the two hospitals address the misunderstanding and negative impression that patients might have about low-charge beds. For example, the hospitals can indicate clearly that low-charge beds are of the same standards and they deliver the same services as ordinary hospital beds do. The hospitals can also rename such beds, giving them a more positive connotation (e.g. concessionary beds).

5.43 Furthermore, as private medical practitioners often refer patients to public or private hospitals, the private hospitals can provide regular information to all private medical practitioners in Hong Kong on the low-charge bed services and remind them that they can pass the information and let their patients decide whether to use such services.

RECOMMENDATIONS

5.44 In view of the above, The Ombudsman has made the following nine recommendations to FHB, DH and HA:

FHB and DH

(1) observe the utilisation of low-charge beds and proactively explore ways to better utilise low-charge beds and revisit the relevant policy when reviewing the policy of service packages (see **para. 5.14**);

(2) make good use of various channels to strengthen its promotion of low-charge beds among members of the public, such as putting up posters or notices in public hospitals (see **para. 5.37**);

(3) proactively explore other means to make low-charge beds more appealing, such as making suggestions to the two private hospitals about using their low-charge beds to offer service packages at lower prices (see **para. 5.37**);

(4) discuss with Hospital B on further increasing the number of low-charge beds in its New Wing (see **para 5.40**);

(5) suggest the two private hospitals enhance the publicity of their low-charge beds, such as providing regular information to all private

medical practitioners in Hong Kong on the low-charge bed services, and addressing the misunderstanding and negative impression that patients might have about those beds (see **paras. 5.41-5.43**);

HA

(6) review the arrangement for referral of patients during influenza surges to investigate why it has been ineffective, review the existing arrangements and make improvement. For example, relaxing the restrictions on referral of patients and simplifying the relevant administrative work (see **paras. 5.20-5.24**);

(7) improve the reservation arrangement for low-charge beds when the referral agreements are activated during influenza surges to avoid wasting resources (see **paras. 5.18 and 5.24**);

(8) depending on the effectiveness of referrals in future, proactively consider allowing such referrals to be made beyond influenza surges (see **para. 5.26**); and

(9) collaborate with the two private hospitals to explore other feasible measures to better utilise the low-charge beds for diversion of public hospital patients, such as encouraging patients who have made appointments or are waiting to receive treatment to use the low-charge beds in private hospitals, and explore the possibility of referring patients to low-charge beds under public-private partnership programmes (see **paras. 5.27-5.34**).

ACKNOWLEDGEMENTS

5.45 The Ombudsman thanks FHB, DH, HA and the two private hospitals concerned (i.e. Hospital A and Hospital B) for their full cooperation during the course of this investigation.

Office of The Ombudsman
Ref: OMB/DI/433
July 2020

Annex

Figure 1：Conditions for Using Low-charge Beds in Hospital A

Terms and Conditions for Admission to Low-Charge Beds at the [redacted] Hospital
(Should be read and signed by Patient before Admission)

1. [redacted] Hospital currently provides 103 low-charge beds pursuant to the conditions of government land grant. Patients may be admitted to these beds for undergoing elective investigation or treatment, including general medical and surgical treatments. The beds are not intended for patients requiring long term nursing care.
2. Normally, the permitted length of stay is up to 7 days. This is to allow better bed turnover thus more patients can enjoy this benefit.
3. Low-charge beds may also be open to "day case" patients with genuine need for hospital beds, limiting to a) Haemodialysis; and b) operative or interventional procedures performed under sedation / anaesthesia (excluding no anaesthesia or local anaesthesia)
4. To be eligible for admission, a patient must be a permanent resident of Hong Kong SAR holding a valid Hong Kong Permanent Identity Card.
5. Patients listed below are not eligible for admission :-
   a. Those requiring emergency or acute medical care
   b. Their medical or surgical conditions requiring special/acute care and monitoring and single room accommodation
   c. Treatment contravenes the teachings of the Catholic Church
   d. Minor patients
6. The charges:-
   a. There is a fixed daily maintenance charge of HK$120 per day which covers accommodation, food and nursing services. (Note: for day case, HK$96 for daily maintenance similar to that of HA hospital)
   b. Some expensive investigative / therapeutic / radiological services, drugs, implants, facilities, and services are not owned by the Hospital and they are provided in the form of consignment. To avoid doubt, low-charge bed patients will be charged at hospital cost for these items and services
   c. Apart from (b) above, the patient will be charged at 50% of the charge applying to the Hospital's second class bed.
   d. If upon or after admission, patient is required to be transferred to isolation ward or special care unit, then all Hospital charges incurred in isolation ward or special care unit will be charged as that particular bed class.
   e. If upon or after admission, the patient requests transfer to a bed of another class, then all the hospital charges and doctor's fees applicable to the latter class will be applied from the point of transfer.
7. If, during patient's stay in the low charge ward, he/she requires emergency/acute medical care or if patient's condition becomes beyond the ward's ability to manage, the Hospital may have absolute discretion to transfer the patient to another ward within the Hospital or to another hospital under the Hospital Authority where the benefit of low charge bed will not apply.
8. Low-charge beds cater primarily for patients with financial needs, e.g. those without or with insufficient medical insurance coverage. If the ward is full, priority will be given to these patients who may be subject to financial / insurance coverage screening.
9. Prior to admission into a low-charge bed, the admitting doctor and patient will be required to confirm in writing that they agree to the terms set out above. Such terms may be varied in writing by the Hospital from time to time without notice.
10. The Hospital may at its absolute discretion determine whether or not to allow admission of a particular patient into a low-charge bed.

[redacted]
Admission Department

Patient's Label

I ________________________________ (name of patient) agree to be admitted to a low-charge bed on the terms set out above.

Annex

Figure 2：Conditions for Using Low-charge Beds in Hospital B

(A) General

1. In accordance with the conditions set out in the land grant, the Hospital provides 61 low-charge beds admitting patients, which are currently located at the following wards:
   - Integrated Unit (3/F, Old Wing): 37 beds
   - Gynecological Unit (12/F, Main Tower): 12 beds
   - Surgical Unit (15/F, Main Tower): 12 beds
2. The patient should be at 15 years of age or above and holder of Hong Kong permanent identity card.
3. Priority will be accorded to patients referred from the hospitals of Hospital Authority to [redacted] Any patients admitted into low-charge beds under the care of Resident, Associate or Visiting Doctors are on a first-come-first-served basis. Priority will be given to the patients without medical insurance coverage or with minimal coverage, if the number of applications exceeds the number of low-charge beds available.
4. Day cases, limited to any operative or interventional procedures performed under sedation or anaesthesia excluding local anaesthesia, could also be admitted into low-charge beds.

(B) Fee and Charges for Low-charge-beds

1. The daily maintenance charge for low-charge beds will be HK$120 which covers bed, three meals and general services including nursing. For day-case patients, a day case charge of HK$96 which includes bed, one meal and general services including nursing will be applied. Special attention is drawn to the fact that the Surgeon's fee, the Anaesthetic fee, the Doctor's ward round fees, the Clinical Pathologist's charges and the other hospital charges listed out in B(2) and (3) below are excluded from the above daily maintenance charge.
2. The expensive items, i.e. drugs, medical supplies and devices, surgical implants, radioactive tracer isotopes, consignment items and third party charges, are charged at procurement cost plus administrative charge of not more than 10% of the procurement cost.
3. Except for the expensive items listed in B(2) above, patients have to pay for the other hospital charges, which are fixed at not exceeding 50% of the similar charges applied to second class beds. However, "Discharge Medications" is considered as out-patient's medications, and will not be included in the low-charge bed scheme.

(C) The preferential terms applicable to low-charge beds are excluded from the following conditions:

1. After admission into the low-charge bed, the patient requests to transfer to other bed class of non-low-charge bed; or
2. The Hospital has the absolute right to arrange the patient to transfer to other appropriate ward such as isolation/special unit, or to the hospital of Hospital Authority for continuation of care if the patient requires emergent or acute care upon the change of condition that is beyond the scope of services being taken care in the above-mentioned Low-charge Bed Units.

In the above conditions, except for transferring to the hospitals of Hospital Authority, all the hospital charges will be reverted to the prices corresponding to the bed class since the day of transfer.

(D) Others

1. Before admission, the attending doctor and the patient have to sign to accept the above conditions. The Hospital reserves the right to change or amend the conditions without prior notification.
2. The Hospital reserves the right and has the final decision of admitting patients into the low-charge beds.